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Chemist&Druggist
The Newsweekly for Pharmacy

C&D

2 July 2005

Draft law may mean 5-year ban for striking off

Welsh rule out POM central purchasing

DoH takes first step in primary care overhaul

Medicines information and the future

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POLICY

'Striking off' may last five years

by Adrienne de Mont

Pharmacists who have been struck off the Register by the Royal Pharmaceutical Society will not be able to practise again for at least five years if new powers come into effect.

At present, the Royal Pharmaceutical Society's Statutory Committee can use its discretion in deciding whether a pharmacist's name should be restored to the Register – in exceptional cases this has been after as little as six months.

But the latest draft Section 60 Order proposes that, where a pharmacist's or technician's name has been removed as a result of misconduct or a conviction, the person cannot apply for restoration until five years after the date of removal.

If unsuccessful, no further application can be made for 12 months; if again unsuccessful, the right to make further applications could be suspended indefinitely.

David Reissner, a partner with law firm Charles Russell, outlines these more "draconian" requirements in an article in *C&D* this week (*pages 26 & 27*), compiled from documents obtained under the *Freedom of Information Act*. The draft proposals have yet to appear in a formal consultation.

Pharmacists who have been struck off for misconduct would also be banned from any involvement in a pharmacy business whereas, in the past, such pharmacists have been able to transfer their business to a company, appoint a superintendent and then continue to deal with administration or help with dispensing.

EDUCATION

Gulf grows between graduates and pre-reg places

In 2010, the number of pharmacy students graduating from schools of pharmacy in the South East of England will be double the number of pre-registration training places available.

This could either lead to "better pharmacists", or it could result in pharmacy losing its status as a vocational course, warned Richard Cattell, South West Education and Medicines Information director, at last month's MI conference (*see page 28*).

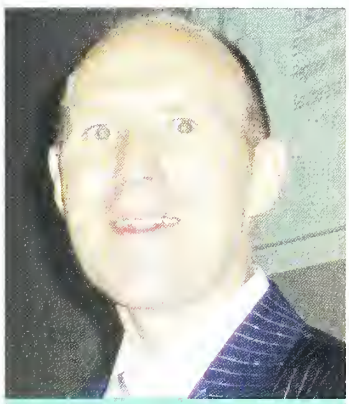
David Webb, clinical pharmacy director for London Pharmacy Services, added: "This may be geographical, so if the graduates are mobile, it may not be a problem.

"There are jobs for them all, but we need to relieve the bottlenecks in the system... there is a danger pharmacy will lose its unique selling point and not be the banker it is now."

Mr Webb called on the Royal Pharmaceutical Society to look at "how it signs off registration".

He also criticised the RPSGB for accrediting new MPharm courses without first looking at the workforce

"There are two options," he said. "Either we don't do anything and let natural selection take over, or the Society looks at the workforce and addresses its needs." **AF**



David Webb: "We need to relieve the bottlenecks in the system"

Richard Cattell: pharmacy could lose vocational status

NPA works on pre-reg 'clearing'

The NPA is developing a web-based forum to help pharmacy graduates find pre-registration training places.

NPA education and training head Lesley Johnson said the organisation was working on the 'clearing house' in response to members' requests. Pre-registration tutors would be able to post details of their training packages on the site and students could then approach pharmacies directly, explained Ms Johnson.

The forum is part of a package being developed by the NPA that will incorporate existing training weekends and resources for pre-registration students. When launched next summer, Ms Johnson said it would include help for pharmacists to gain accreditation from the Royal Pharmaceutical Society for their premises, training programmes or to become tutors.

RPSGB pre-registration head Peter Burley said: "It's an absolutely brilliant idea. Any help for trainees is welcome." But he disputed that there was an imbalance between the number of pharmacy graduates and training places.

WALES

Welsh rule out POM central purchasing

The Welsh are still hankering after saving money for the Cardiff Government through central purchasing.

Although the National Assembly has finally abandoned thoughts of negotiating central deals with manufacturers for 300 prescription medicines – which would have saved perhaps £50 million – it is now examining another field of Assembly-funded spending.

The cost of sip feeds, which are priced higher for use in primary care than in hospitals, will now be examined for possible central purchasing.

The formal abandonment of the drugs plan has been warmly welcomed by community pharmacists, although it had been clear for some time that the Assembly's original plans had drawn to a halt.

The scheme was dropped when the health department in London, acting on a UK basis, negotiated lower prices for primary care medicines.

"This greatly reduced the scope for savings that could be obtained by introducing centralised procurement," said the auditor general's memorandum.

When reported to the Assembly's audit committee last week, NHS director Ann Lloyd showed signs of resurrecting a variation of the proposal that had come originally from then auditor-general Sir John Bourn.

Mrs Lloyd told the committee that the project board, which had been established to oversee implementation of the original plan, was being kept for possible future use.

Yet, by the following day, that board had been disbanded. No reason was given, but some personnel have changed since it was established almost two years ago: both the minister and the auditor-general are new.

But its work will continue being handled by the NHS Industry Forum, which is a sub-group of the All-Wales Medicines Strategy Group.

Its brief is to look at "the option of centralised procurement of non-drug prescribed items, such as sip feeds". **CB**

POLITICS

Pharmacy bodies prepare for primary care overhaul

Pharmacy organisations have vowed to boost the profile of community pharmacy in response to a Government consultation on the future of primary care services.

The consultation precedes the White Paper on *Health outside Hospitals*, which will reshape the structure of primary care, and is due at the end of the year.

The Government will collect the views of thousands of people, at both local, regional and national level, on NHS services such as GP surgeries, walk-in centres and social and community care, health secretary Patricia Hewitt has said. "I want to involve patients, public and staff in designing family health and social care to meet the challenge of ensuring primary healthcare services can meet changing expectations," she said.

Ms Hewitt added that there would be a particular focus on ensuring that the views of disadvantaged groups and communities were heard, but that there was no predetermined blueprint.

Commenting, NPA director of practice, Colette McCreedy, said that although the NPA had not made a decision yet on its approach, its aim would be to engage both with the DoH and the public to make community pharmacy a substantial focus of its submission. "This is a real chance for pharmacy to feature prominently," she said.

Pharmacy will be pushing against an open door, Ms McCreedy believes, adding: "All recent policy documents recognise that pharmacy is a key player in health outside hospital and that for all the groups mentioned, pharmacy has a key role to play."

Echoing Ms McCreedy's comments, Alastair Buxton, PSNC head of NHS services, said: "The White Paper will be very important for the future development of community pharmacy; it is likely to increase the opportunities available for contractors. PSNC will be making a response to this important consultation and also working behind the scenes with other pharmacy bodies to shape thinking now."

Hemant Patel, RPSGB president, also urged community pharmacists to get involved in this consultation.

He said community pharmacists were key stakeholders in the future of primary care services and that their voice needed to be heard as the Government developed its thinking.

AC

Inbrief

Skilful 897

Some 897 pharmacists have so far become accredited to provide advanced services under the new pharmacy contract by passing the Skills for the Future training course.

The course, published by *C&D* in association with PSNC, consists of 20 modules and is supported by an assessment CD-Rom containing case studies. Over 4,500 pharmacists have registered for the training course to date.

For more information:

www.dotpharmacy.com

mprebble@cmpinformation.com

Tel: 01732 377269

Commissioning aid

The NPA has developed a resource for members to help them understand the options that PCTs have for commissioning services.

It emphasises that commissioning is more than just agreeing contracts. It also covers a cycle of planning services, contracting for those services, monitoring service delivery and revising contracts.

The NPA says pharmacists have the opportunity to become involved in providing almost any healthcare service in primary care as long as the service meets local healthcare needs, reaches the appropriate standards and provides value for money. NPA NHS liaison manager Neal Patel said the opportunity for pharmacy to benefit was considerable as it increased access and choice in primary care provision.

Update MCQ enclosed

This week's issue contains the questionnaire for the following Pharmacy Update modules carried in June:

- Headache part 2 (1339)
- Basic bugs part 3 (1340)
- Minor ailments part 1 (1341).

Pharmacy Update is a distance learning programme accredited by the College of Pharmacy Practice. Previous modules can be accessed on the *C&D* website *www.dotpharmacy.com*. Further information is available from Mary Prebble on 01732 377269.

Genus Pharmaceuticals supports the MCQ and telephone marking service.

Newsdesk
01732 377688

Patients with mental illness still dying young

by Fiona Salvage

Mental health guidelines have had no impact on patients' physical health or their preventable poorer health outcomes, said a report launched this week.

Running On Empty revealed that patients with severe mental illness were three times more likely to die prematurely from conditions despite the *National Service Framework for Mental Health* and NICE guidance.

These poor health outcomes could have been prevented by simple measures such as blood pressure monitoring, blood glucose testing, weight measurement and giving healthy eating and lifestyle advice. These checks could be carried out by community pharmacists as part of in a medicines use reviews, authors present at the launch agreed.

How to get funding

Kevin Gournay, head of psychiatric nursing at the London Institute of Psychiatry, offered advice on how pharmacists could approach PCTs for funding for this service.

Pharmacists should use the *Running On Empty* report's bibliography as initial evidence for any application to their PCT for running MURs for patients with severe mental illness, said Professor Gournay.

The report itself identifies the scale of the problem and outlines the successful projects that are examples of best practice, added David Yeomans, consultant psychiatrist at Leeds University.

Finally, tell the PCT "here's a case of need and examples of how projects were done and how we want to do it in this locality", Dr Yeomans explained.

For more information:
www.rethink.org

[illegible] didn't miss a glimpse of their [illegible] by selling OTC [illegible] last weekend's event. Revellers suffering from eye infections capitalised on the [illegible] the festival's on-site pharmacy, according to Mr Hutchins, who is branch [illegible] Plymouth

Beware of bogus callers, warns locum

A locum pharmacist in South Wales is warning pharmacists to be aware of hoax telephone calls in which they may be asked to reveal their name, registration number and home address.

Tony Blasebalk told *C&D* that he received a bogus call from a man claiming to be from a pharmaceutical company who wanted to send the pharmacy some risk assessment packs free of charge.

When Mr Blasebalk dialled 1471 to find out who had phoned, he received the 'caller withheld their number' message.

Geraldine Clark, chief press officer at the NPA, said this type of call is not unusual. "A number of anxious members have contacted us about odd phone calls over the past couple of years," she said. "The callers often say they are doing a survey for the NPA and ask for the pharmacist's name. They often leave a name and return number but when the pharmacist dials and asks for the person whose name they've been given, that person is not known at the organisation.

"These calls are intermittent and are made all around the country; there is no pattern to them except that all callers are male," said Ms Clark. "It's mysterious and we've published warnings in our newsletter. It's hard to work out what the callers are trying to achieve."

The RPSGB said it was concerned to learn that members were receiving such calls and advised them to take care when being asked to provide personal information. Pharmacists should take appropriate steps to satisfy themselves that the caller and request for information was genuine, it added. **JE**

LEGAL

PPA to repay convicted pharmacist

A pharmacist convicted of false accounting is to have part of the sum that he was alleged to have fraudulently claimed repaid by the Prescription Pricing Authority (*C&D, June 4, p8*).

Rajiv Sarna was sentenced at Winchester Crown Court in May to six months in prison for allegedly defrauding the NHS of £23,000 by inflating claims made under the Essential Small Pharmacy Scheme. But, according to the NHS Counter Fraud and Security Management Service (CFSMS), the actual shortfall agreed by the court was £7,500 and the PPA will repay the difference to Mr Sarna.

The figure of £23,000 was initially put to the court to explain the overall value of the money allegedly obtained by false accounting, said the CFSMS. But, following a submission by the defence and based on calculations by the PPA, the actual shortfall was agreed by the court to be £7,500, the CFSMS has confirmed. **GP**

NPA

Resource guide for patient surveys

The National Pharmaceutical Association is developing a resource pack to help pharmacists undertake an annual patient satisfaction survey as specified in the new contract.

The NPA is working with Client-Focused Evaluations Program Surveys in Exeter, which specialises in producing patient feedback surveys for healthcare professionals, and Devon LPC.

The resource involves pharmacy contractors carrying out a patient survey using a validated questionnaire designed and produced by CFEP.

The completed questionnaires will be analysed and the results fed back to the contractors involved.

The NPA resource pack will be ready for distribution in the autumn.

In addition to this free resource, the NPA is developing a patient survey analysis and benchmarking service which members will be able to purchase. **JE**

IF YOUR CUSTOMERS THINK A NASAL SPRAY COULD NEVER BEAT ANTIHISTAMINE TABLETS

THEY'RE SWALLOWING A MYTH[1-9]

It's time to give allergy sufferers the facts. Tell them that an anti-inflammatory nasal spray, like Flixonase Allergy Nasal Spray, is effective for itchy eyes[1-4,10-12] and beats one-a-day antihistamine tablets hands down on relieving sneezing, runny noses, nasal congestion and groggy heads due to allergy.[1-9] And all in a once-a-day spray. Recommend Flixonase Allergy, because nothing is more effective without prescription.

SO MUCH MORE THAN AN ANTIHISTAMINE

Flixonase Allergy Nasal Spray Product Information. Presentation: Aqueous nasal spray suspension containing 50 micrograms of fluticasone propionate per spray. **Uses:** Prevention and treatment of allergic rhinitis. **Dosage and administration:** Intranasal use only. *Adults and the healthy elderly:* Two sprays into each nostril once a day, preferably in the morning. Use twice daily if required. Do not use more than 4 sprays a day in each nostril. Prophylaxis of allergic rhinitis requires treatment before contact with allergen. *Children under 18 years:* Not to be used. **Contraindications:** Known hypersensitivity to ingredients. **Precautions:** If symptoms have not improved after 7 days or, if symptoms have improved but are not adequately controlled, consult a doctor. Not to be used for more than 3 months continuously without consulting a doctor. Consult a doctor before use in: concomitant use of other corticosteroid products, nasal/sinus infection, recent nasal injury/surgery, nasal ulceration. Risk of adrenal suppression with higher than recommended doses. Significant interactions between fluticasone propionate and potent inhibitors of the cytochrome P450 3A4 system, e.g. ketoconazole and protease inhibitors, such as ritonavir, may occur. This may result in increased systemic exposure to fluticasone propionate. **Side effects:** Dryness and irritation of the nose and throat, unpleasant taste and smell, headache and epistaxis. Hypersensitivity reactions including skin rash and oedema of the face or tongue. Rarely anaphylaxis/anaphylactic reactions and bronchospasm. Extremely rarely nasal ulceration and nasal septal perforation usually following previous nasal surgery. **Pregnancy and lactation:** Do not use except with medical advice. **Legal category:** P. **Product licence number:** PL 10949/0360. **Product licence holder:** Allen & Hanburys, Stockley Park, Middlesex, UB11 1BT. Further information available on request from Medical and Consumer Affairs, GlaxoSmithKline Consumer Healthcare, Brentford, Middlesex, TW8 9GS. **Package quantity and RSP:** 60 spray pack £6.79. **Date of preparation:** December 2002. **Flixonase** is a registered trade mark of the GlaxoSmithKline group of companies.

References: 1. Ratner PH *et al.* J Fam Prac 1998; **47:** 118-125. **2.** Stricker WE *et al.* Ann Allergy Asthma Immunol 1998; **80:** 115. **3.** Kaszuba SM *et al.* Arch Intern Med 2001; **161:** 2581-2587. **4.** Jordana G *et al.* JACI 1996; **97:** 588-595. **5.** Gehanno P and Dassonneville J-L. Allergy 1997; **52:** 445-450. **6.** Weiner JM, Abramson MJ, Puy RM. BMJ 1998; **317:** 1624-9. **7.** Foresi A. Allergy 2000; **62:** 12-14. **8.** Stricker *et al.* J. Fam. Pract. 1998; **46:** 14-22. **9.** Vervloet D, Charpin D, Desfougeres JL. Clin Drug Invest 1997; **13(6):** 291-298. **10.** Bernstein DI *et al.* Clin Exp Allergy 2004; **34:** 952-957. **11.** Van Bavel JH *et al.* Ann Allergy Asthma Immunol 1997; **78:** 128. **12.** Darnell *et al.* Clin. Exp. Allergy 1994; **24:** 1144-1150.

GlaxoSmithKline
Consumer Healthcare

Urgent need to lobby for out-of-hours provision

by Adrienne de Mont

Pharmacists risk losing extra payments if they don't join forces and lobby to provide much needed out-of-hours cover, AAH Pharmaceuticals group managing director has warned.

Steve Dunn said pharmacists must recover the lobbying power they found over control of entry regulations and which has "strangely evaporated".

"Pharmacists need to call for prescribing rights and resources to fill the out-of-hours void, but there is no coherent voice on this issue, not least from its representative body," he said.

Massive publicity over the failings of the new arrangements reinforced the case for pharmacists to offer such services. Mr Dunn suggested that independent prescribing, or pharmacists prescribing from a limited formulary, could meet a large percentage of the cover.

"Pharmacists could also lobby for extra payment for covering Saturdays when the GPs are closed, providing a commercial and medical reason for staying open when scripts are not being produced," he added.

NHS call centres, which have failed to cope with the demand, are not the total solution "and certainly not when there is a qualified, accessible resource on the high street to relieve much of the pressure. It is telling that NHS24 calls, a third of which are medicines related, spike on a Saturday," said Mr Dunn.

Promising to do all in his power to persuade the Department of Health to extend prescribing rights to pharmacists, Mr Dunn said: "Pharmacists have much to vex them, with doctors getting paid to do less and with GMS contract overspends seemingly eating into the pharmacy pot. But with so many categories of health professionals poised to grab any extra roles and income streams, pharmacists cannot afford to be defeatist and take a wait and see approach."

LEGAL

Viagra faker sentenced

Mohammed Bhatti, a Reading estate agent convicted of selling counterfeit Viagra on June 3, has been fined £1,250 and ordered to do 150 hours' community service.

Mr Bhatti, of Woodley, admitted two charges linked to fake Viagra sales valued at nearly £500,000 at Isleworth Crown Court last month.

Pfizer had seen Viagra advertised for sale by BRR Pharma, a supply company run by Mr Bhatti's uncle, Mohammed Khan. An investigation culminated in a meeting at a hotel where MHRA and police officers found Mr Bhatti and his uncle, now thought to be in Pakistan, with 22,000 fake Viagra tablets.

Judge Richard McGregor-Johnson accepted that Mr Bhatti was not the 'prime mover' and said a custodial sentence was inappropriate.

[illegible] opportunity to discuss community [illegible] visited the shop last Friday. Welsh [illegible] said she found the visit to JG [illegible] informative and very beneficial". [illegible] the Royal Pharmaceutical Society in Wales [illegible] profile of the profession to [illegible] pharmacy, from the left are: Ms Williams, [illegible] Mair Davies

Pharmacies perk up profits at Alliance UniChem

A thriving pharmacy division has helped drive financial success at healthcare group Alliance UniChem during the first half of 2005, according to the company's pre-close period statement.

The group, which will announce its six-month results on July 28, said its retail division had continued to "perform strongly" compared to a struggling wholesaler market.

Alliance UniChem said its pharmacies had successfully adapted to the new contract and its acquisition programme, which included the purchase of Bairds Chemists, was ahead of schedule.

But the company said growth in its wholesale division had been slower than in previous years because of PPRS price cuts in the UK and regulatory price changes in Spain. **MG**

PRACTICE

Compliance alert scheme pioneered

Pharmacists in Staffordshire and Newcastle are to play a central role in a pioncering, cross-agency electronic reminder scheme designed to improve compliance in older people.

The initiative, developed by the pharmacists and local housing services, social care, Newcastle and South Western Staffordshire PCTs and an IT provider, gives patients free electronic boxes, which alert them when it is time to take their medicine.

If the user does not acknowledge the reminder by pressing a button on the box, call centre staff will telephone them.

Twenty pharmacists are participating in the two-centre scheme, which involves them visiting the older person at home to discuss medicine needs and assessing them for the scheme. Each is being paid £25 an hour.

Launched last month and running until October, the project has been initially funded by PCTs, Staffordshire Social Care & Health and Tunstall, the technology provider.

This is the first time electronic prompting has been used in Britain.

It is hoped that short-and long-term evaluations will pave the way for on-going funding. **AC**

Correction

The e-mail address for Rowlands' human resources manager Sandra Rowlands should be *sroberts@rowlandspharmacy.co.uk* and not as it appeared in last week's recruitment feature (*C&D June 25, page 40*).

Questiontime

This week's question:
What do you think of the NPA's proposed 'clearing' system for pre-registration students?

- **Will encourage more people to take on pre-reg students**
- **Will make no difference as not enough placements exist**
- **It should be the RPSGB's responsibility to do this**

You have until noon on July 5 to vote at *www.dotpharmacy.com*. We will publish the results on July 9.

IF YOU LIKE THINGS CLEARED FAST, FILL YOUR SHELVES WITH BENADRYL.

Benadryl has the widest range of allergy relief products so you can be sure that there's one to suit everyone. For instance Benadryl Plus is the only non-drowsy* allergy relief capsule with added decongestant. Essential for the 78% of allergy sufferers who experience congestion as part of their symptoms.** Just one of our range of products specifically targeted to relieve individual ailments. And to do it fast.

www.allergyadvice.co.uk

Pfizer Consumer Healthcare

*Cetirizine/Acrivastine at the recommended dose does not normally cause drowsiness. However, rare cases of drowsiness have been reported. **European Claims Research 2003.

Benadryl Allergy Relief Product Information: Presentation: Acrivastine 8 mg **Uses:** Allergic rhinitis. Also chronic idiopathic urticaria, symptomatic dermographism, cholinergic urticaria and idiopathic acquired cold urticaria. **Dosage:** Adults and children aged 12 - 65 years: one capsule up to 3 times a day. **Contraindications:** Hypersensitivity to acrivastine or triprolidine. Significant renal impairment. **Precautions:** Concomitant use of acrivastine with alcohol or other CNS depressants may produce additional impairment **Pregnancy & lactation:** Not recommended. **Side effects:** Rarely drowsiness. **RRP (ex-VAT):** 12s, £3.70; 24s £6.43 **Legal category:** P. **PL holder:** Pfizer Consumer Healthcare, Walton-on-the-Hill KT20 7NS. **PL number:** 15513/0035 **Date of preparation:** Dec 2004 **Benadryl Plus Capsules Product Information: Presentation:** Acrivastine 8mg and pseudoephedrine 60mg. **Uses:** Allergic rhinitis. **Dosage:** Adults and children 12 - 65 years: One capsule as necessary, up to three times a day. **Contraindications:** Hypersensitivity to any of the ingredients or triprolidine. Severe hypertension, significant renal impairment or severe heart disease; those who have taken MAOIs in the preceding 14 days. **Precautions:** Diabetes, hyperthyroidism, heart disease, hypertension, glaucoma or prostatic enlargement. It is usual to advise patients not to undertake tasks requiring mental alertness whilst under the influence of alcohol or other CNS depressants. Patients taking sympathomimetics, antihypertensives, and tricyclic antidepressants. Effects of alcohol or other CNS depressants may be enhanced. **Pregnancy & lactation:** Not recommended. **Side effects:** Rarely drowsiness, CNS excitement, urinary retention skin rash, **RRP (ex-VAT):** 12s £4.25, 24s £7.65 **Legal category:** P **PL holder:** Pfizer Consumer Healthcare, Walton-on-the-Hill KT20 7NS. **PL number:** 15513/0017 **Date of preparation:** Dec 2004 **Benadryl Skin Allergy Relief Cream and Lotion Product Information: Presentation:** Cream or lotion containing Diphenhydramine hydrochloride 1%, Zinc oxide 8% and Camphor 0.1%. **Uses:** Relief of skin allergies and irritations. **Dosage:** Children and adults: apply topically to affected area three or four times a day. Contraindications: Chickenpox, measles, broken skin or large areas of skin, except under medical supervision. Concomitant use with other diphenhydramine-containing drugs. **Precautions:** Do not apply to raw or broken skin or mucous membranes. If burning sensation or rash develops, or condition persists, discontinue treatment. Avoid contact with eyes. **Pregnancy & Lactation:** Not recommended **Side effects:** Rarely skin irritation or sensitivity. **Price (ex-VAT):** Cream and Lotion £3.02 **Legal category:** P **PL holder:** Pfizer Consumer Healthcare, Walton-On-The-Hill KT20 7NS. **PL number:** Cream: 15513/0078; Lotion: 15513/0077 **Date of preparation:** January 2005. **Benadryl Allergy Oral Solution Product Information: Presentation:** Cetirizine 1mg/ml **Uses:** Symptomatic treatment of rhinitis and urticaria in children 6 and over; seasonal allergic rhinitis in children 2 to 5 years of age. **Dosage:** Age 6 -11: either 5ml twice daily or 10ml once daily. Age 12 and above: 10ml once daily. Age 2-5: either 5ml once daily or 2.5ml twice daily. **Contraindications:** Hypersensitivity to any of the ingredients. **Precautions:** in renal insufficiency, half the recommended dose. **Pregnancy & lactation:** Not recommended. **Side effects:** Occasionally headache, dizziness, drowsiness, agitation, dry mouth or gastrointestinal discomfort. **RRP (ex-VAT):** 100ml. £4.25 **Legal category:** P **Licence holder:** Pfizer Consumer Healthcare, Walton-on-the-Hill KT20 7NS. **PL number:** 08972/0033. **Date of preparation:** March 2005 **Benadryl One A Day Relief Product Information: Presentation:** Cetirizine 10mg **Uses:** Symptomatic treatment of perennial and seasonal allergic rhinitis and idiopathic urticaria. **Dosage:** Adults and children aged 12 years and over: One 10mg tablet daily. **Contraindications:** Hypersensitivity to any of the ingredients. **Precautions:** Caution if driving or operating machinery. As with other antihistamines avoid excessive alcohol consumption. **Pregnancy & lactation:** Not recommended. **Side effects:** Occasionally headache, dizziness, drowsiness, agitation, dry mouth or gastrointestinal discomfort. **RRP (ex-VAT):** 7 £3.79 Legal category: GSL. **PL holder:** Pfizer Consumer Healthcare, Walton-on-the-Hill KT20 7NS. PL: 15513/0118. **Date of preparation:** March 2005.

Generics UK pays £12m to settle legal case with DoH

by Asha Fowells

Generics UK has paid the Department of Health £12 million compensation for alleged price-fixing of generic drugs.

The payment was made on a full and final basis and without admission of liability following claims that the company acted in an anti-competitive manner. The settlement is part of a case that involves three separate sets of proceedings issued between 2002 and 2004 against several generics manufacturers. Ranbaxy was the first company to settle – for £4.5m – earlier this year (*C&D, April 9, p10*).

As part of the settlement, the DoH said that Generics UK has agreed to provide "co-operation in connection with the continuing claims regarding the alleged price fixing arrangements".

NHS Counter Fraud Services director Jim Gee issued a warning to the companies still involved in the cases, saying: "They should recognise our determination to press on... we are determined to recover the NHS's losses and shall do so with the benefit of all the evidence available to us."

In a joint statement, the generics firm and the DoH said they "look forward to a strong working relationship in the future and are committed to the highest standards of healthcare at all levels".

Retail blues could hit profits

A recent slump in high street sales could hit profits at many community pharmacies, experts have warned.

Pharmacists could suffer a sharp decline in demand for toiletries and OTCs after a report published recently by the British Retail Consortium revealed like-for-like retail sales had declined by 2.4 per cent.

NHS prescription reimbursements would fail to offer total protection for many pharmacists against a future recession, said John D'Arcy, chief executive at the National Pharmaceutical Association. "Nobody is bullet-proof and prescription business only offers a degree of income. If toiletries and OTCs contribute a large proportion of business then a decline in consumer spend is going to hurt," he commented.

Declining consumer confidence would have a universal effect on businesses, said the Confederation of British Industries' chief economic advisor Ian McCafferty. "Recent months have seen economic growth slow across the economy. Unhappy ranks of retailers and manufacturers are struggling in the face of softer demand."

Rising rates and electricity are also creating a hostile trading environment. Average business rates are set to increase by 7.5 per cent in 2005, according to *The Times*, while Energywatch said electricity bills have jumped by 17 per cent since 2004.

Growing overheads are one of many pressures pharmacists must face, said Graham Phillips, a Hertfordshire pharmacist. "Rising electricity and business rates are a double whammy for me. But the real worry is the increasing number of people who are picking up medicines at supermarkets," he said. **MG**

MI databank launched

A paperless medicines information enquiry management system was launched at last month's UK Medicines Information conference.

MiDatabank has been designed to replace the paper-based records and computer systems currently used by NHS MI services, said Steve Moss, managing director of CoAcs, which has developed the system in partnership with UKMi. The multi-user, secure package comes with helpdesk support, automatically backs up information and allows audit trails.

For more information:
www.ukmi.nhs.uk

Lloydspharmacy is first with Radiovision

Lloydspharmacy has become the first UK retailer to launch 'Radiovision', a synchronised radio and video broadcast.

Launched on Friday in six of its busiest stores, the three-month trial of Radiovision combines the Lloydspharmacy Live! in-store radio broadcasts with video. It is to be used initially to explain products and services, educate customers on key health messages such as suncare and prescription collection services, and to reinforce brand awareness. It will also be used to provide current affairs and music.

Lloydspharmacy is the first retailer in the UK to trial the system, which is a product of Immedia Broadcasting, the company run by former Radio One DJ Bruno Brookes.

Mr Brookes describes Lloydspharmacy Live! in-store radio, which has broadcast across the 1,400 Lloydspharmacy chain for two years, as a powerful communication tool for healthcare messages, which has driven incremental sales.

Mark Green, below, commercial director at Lloydspharmacy, added: "We hope by introducing the Radiovision concept this will enhance even further our product and service offering." **AC**

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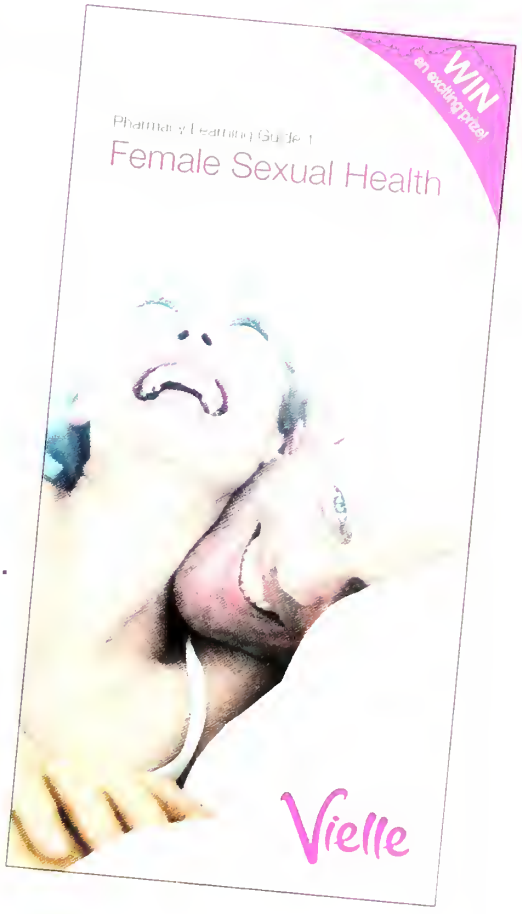

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Source: Dunn et al, Sexual Problems: a study of the prevalence and need for health care in the general population in the UK, Family Practice International Journal (1998); 15:519-524.

E-mail your views to chemdrug@cmpinformation.com

The BMJ bites back over 'headline-grabbing ibuprofen study'

Julia Hippisley-Cox and Carol Coupland, authors of a study in the *BMJ* which gained widespread media coverage, respond to concerns raised by the RPSGB's David Pruce

Regarding the study we published in the *BMJ* on June 11, (*C&D, June 18, p8* and *June 25, p5*). There are several points which need clarification and we hope that we can do this for you.

In his letter, Mr Pruce mentions that:

"We are concerned that no other possible explanation for the findings was addressed in the paper before concluding that the NSAIDs were a causal factor in myocardial infarction."

This statement is inaccurate on two counts. Firstly, in our paper we did not state causality. Rather, we stated the following in the abstract:

"These results suggest an increased risk of myocardial infarction associated with current use of rofecoxib, diclofenac and ibuprofen despite adjustment for many potential confounders. ... this is an observational study and may be subject to residual confounding that cannot be fully corrected for."

This interpretation was also stated clearly in pages five and six of the paper. It was also reiterated in every single interview with the media.

The statement that "no other possible explanations for the findings were discussed" was also inaccurate. On page five in the 'Discussion of methods' section we discussed other possible explanations for our findings as follows:

"This is an observational study and therefore at risk of confounding. For example, some confounding by indication could be present, such as if patients had been prescribed NSAIDs for chest pain that was actually angina... similarly, we considered whether channelling may explain our results... although we have adjusted for a number of confounding variables some residual confounding may result from misclassification of those variables and confounding by unmeasured variables."

David Pruce makes a point about "poor matching" of cases and controls and says this was raised in the accompanying editorial. This issue, however, was not raised in the *BMJ* editorial – another inaccuracy in David Pruce's letter. We matched on age, sex, practice and calendar year. It would be staggering if we had not found differences between cases and controls for the well established risk factors for coronary heart disease (such as diabetes, hypertension, obesity and smoking). These differences point to the internal consistency of the dataset.

We adjusted for these additional confounding variables in the analysis, which is a well established method of taking account of potential factors and means that factors such as these do not confound the results.

In the methods section of the paper we described two additional models which we carried out to further examine the effects of the differences in prior risk factors of any missing data, the results of which are described in the results section.

"We fitted a second model restricted to cases and controls with complete data for smoking and body mass index. We fitted a third model restricted to patients without either diabetes or ischaemic heart disease in order to reduce possible effects of residual confounding."

We obtained similar results with both of these additional analyses, implying that these factors were not the explanation for our results. This is clearly stated in the results and conclusions.

Lastly, the National Electronic Library for Health *(http://www.nelh.nhs.uk/hth/antiinfdrugs.asp)* published an entirely independent critique of our paper, which said the following:

"How reliable are the conclusions? This appears to be a well-conducted case-control study. It was based on a large general practice-based dataset, with data collected over a four-year period. The cases of heart attack were identified without prior knowledge of drug exposure, and were matched with controls on a number of relevant criteria. The statistical analysis was correct, and presents both adjusted and unadjusted results. The adjusted results accounted for a number of potentially important risk factors for myocardial infarction (age, co-morbidity, smoking habits, use of antidepressants, statins and aspirin), although this data was not complete for all cases.

The authors acknowledge that this study may be at risk of residual confounding. Ibuprofen can be obtained without prescription, and some patients may have been misclassified as not taking ibuprofen; although the authors state that this number is likely to be small. In addition, data on the use of NSAIDs was based on practice prescription records, which do not record whether the patient actually took the drug or for how long. It should also be noted that this study only considered prescribed drugs (people taking prescription painkillers tend to take them at a higher dose and for a longer period than those who buy them over the counter), and that almost 70 per cent of the sample was aged 65 years or over."

Julia Hippisley-Cox, Carol Coupland

National Smoking Cessation Conference views were taken out of context

We are writing in response to your article "Pharmacists left fuming over PCT smoking attack" (*C&D June 18, p12*).

You reported that Mireille Herbert, Quit Smoking service manager, proposed that community pharmacists offered a poor quality and lower standard alternative to full-time specialist treatment staff.

It was not reported that this was in the context of an organised lighthearted debate at the first National Smoking Cessation Conference, and that Ms Herbert was not speaking as a representative of Enfield and Haringey PCTs. We wish to assert in no uncertain terms that these views are not consistent with those held by our organisations, and indeed not supported by our Quit Smoking results last year.


Pharmacists left fuming over PCT smoking attack

by Max Gosney

Both Enfield and Haringey PCTs are very proud of their partnership with local community pharmacists and their significant contribution to our quit rates. In the period January to March 2005, 922 people quit smoking in Enfield and Haringey, one third of them in our local pharmacies.

As a result of these encouraging results, we have increased the resources invested in community pharmacy stop smoking services and we expect up to 2,500 people to quit in our pharmacies this year.

We have now offered training to all of our local pharmacists and most pharmacies now have a fully trained adviser working with the full support and confidence of the PCTs.

We are equally proud of our specialist service, but realise that not all smokers wish to quit in such a structured and formal way.

We believe that community pharmacists offer a highly accessible and good quality service that responds well to the needs of our local populations, often including those who do not traditionally access other local services.

Sally Johnson, chief executive, Enfield Primary Care Trust, Tracey Baldwin, chief executive, Haringey Teaching Primary Care Trust

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Comment from the Editor

Our question to pharmacists this week was: **Should there be a ban on smoking in public?**

"I don't think it would be a bad idea, but it could affect businesses"

Julie Shimmins, Bannockburn

"No, I don't mind it"

Safina Aslam, Ashby de la Zouch

"No, I don't think a total ban would be workable"

Donald Maciver, Banbury

Our online poll at *www.dotpharmacy.com* said...

As part of its modernisation programme, the RPSGB had hoped to update its Charter in tandem with new legislation – a Section 60 Order under the *Health Act 1999* – to update its disciplinary powers.

This week, David Reissner, of law firm Charles Russell, gives a strong indication of the new disciplinary powers likely to be bestowed upon the RPSGB. These include the ability to fine pharmacist owners who fail to comply with its inspectors' requests, and a duty on pharmacists to notify the Society if they cannot control their business.

One of the Society's more welcome powers, however, could be the ability to help pharmacists who are unfit to practise due to health problems. Currently, pharmacists who have alcohol and drug problems face being struck off but the draft legislation proposes a Health Committee, which could allow pharmacists to practise subject to conditions.

One power that will not be so welcome, however, is that those struck off from the Register will be unable to apply for restoration for five years. Currently there is no time restriction. Whatever the outcome, the Society has no option but to modernise its fitness to practise role in line with all health regulators: the public will settle for nothing less.

But while the Section 60 Order helps the RPSGB move toward becoming a world class regulator, let's not forget the Society also has a duty to promote the interests of pharmacists in their exercise of the profession of pharmacy – and some evidence of the benefits of belonging to a world class professional body would not go amiss.

But there is also the Government's Foster Review ahead, which will consider the role, structure and number of regulators. Members may consider 2004 as the Society's *annus horribilis* but will 2006 raise further questions?

"Members may consider 2004 as the Society's *annus horribilis*"

Yourviews

E-mail your views to chemdrug @ cmpinformation.com

Martin Sawer, executive director of the BAPW, responds to *Xrayser*

Is wholesaling on the brink?

Xrayser's comments on wholesaling last week (*C&D, June 25, p15*) was a welcome contribution to the debate around the condition of the supply chain. Unfortunately, the author's hope that the BAPW chairman's complaints about the critical condition of wholesaling are exaggerated is misplaced. Stock shortages have never been so bad.

Wholesalers' customers are used to the highest levels of satisfaction – service is rightly expected to be at the highest levels. This ensures patients get the medicines they need on time and pharmacists can stop worrying about where the next delivery is coming from.

The comparison David Cole, our chairman, makes is with the Post Office. Bosses there get excited about service levels which hit low 90 per cent levels, yet last year lost 16 million pieces of mail. Imagine that transposed onto the pharmaceutical wholesaling industry – with a well above inflation price increase slapped on for good measure.

Yet wholesaling and pharmacy is being potentially threatened by exactly the same issue – an inability to meet patient demand and customer expectations which could undermine confidence in the entire supply chain. The BAPW has been concerned about stock shortages for some time and has worked closely with the DoH and manufacturers to fight the fires across the supply chain – none of their making.

But this is not a sustainable state of affairs. As *Xrayser* points out, wholesalers are being squeezed left, right and centre – generics, PPRS, new discount structures and unilateral manufacturers' pricing schemes – and this limits the investment wholesalers can make in core services, let alone the extras customers have got used to.

BAPW is trying to make customers and suppliers aware that through no fault of our own our high service levels are under threat.

Out of stock and out of ideas

I have been spending an increasing amount of my time resolving manufacturers' out of stock situations, so was not surprised to hear the British Association of Wholesalers call the situation "unprecedented" (*C&D, June 14, p25*). A quick count suggests well over 50 lines out of stock at their manufacturer and I have never seen anything like it.

I'm not suffering personally – there is a little more work to do, but it's a great opportunity for dialogue with local GPs. The majority will agree to a blanket substitution policy for most cases. Patients are disturbed by the change but most are quickly found a suitable alternative. Some undoubtedly suffer, even if only slightly. I have yet to hear if anyone's blood pressure has been significantly affected by the switch from Cardura XL to a standard release generic doxazosin, for example.

Wholesalers must be suffering from an increased workload and having difficulty predicting which alternatives to stock up on next. But the ones who stand to lose most are the ones causing the problem in the first place, ie the manufacturers themselves. Every patient prescribed an alternative is a lost sale for them, and once a patient's medication has been changed on the surgery computer it is unlikely to be changed back again. Once GPs have brought Vista-Methasone to the front of their mind as the only steroid ear drop available it is likely to stay there to the exclusion of other preparations (as long as its manufacturers can keep up with the unexpected demand). One Prempak-C patient has been taken off HRT altogether.

The reasons behind the shortages are unclear but I can't help thinking there is something sinister afoot. Manufacturers are not going to shoot themselves in the foot like this without good reason. A lot of recent events have impacted on the supply chain but global corporations should be able to absorb changes like this. And none of them seem too concerned, with Pfizer the only company worried enough to send a rep round with an explanatory letter.

I wonder how bad things would have to get before the DoH intervened. Let's not forget that it was stock shortages that initially triggered the revised generics reimbursement system. Something is obviously wrong somewhere and in this monopoly market the Department has plenty of remedies to choose from. Many of these would be bitter pills for the pharma companies and, as always, pharmacists would be bound to suffer in some way. Let's hope the situation remedies itself and desperate measures are not necessary.

Cartoon by Don Seed

Bravo for a bolshy Society

Well done to the Royal Pharmaceutical Society for its outspoken criticism of a respected journal to support pharmacists and the public. David Pruce has said that the *BMJ*'s press release about the link between ibuprofen and heart attacks was "evidently geared towards getting a headline" (*C&D, June 25, p5*). This is strong stuff indeed from an organisation that usually only makes a statement to "welcome" a report or "accept" new findings.

For the *BMJ*'s own editorial to warn that "these results should be interpreted with caution" suggests that a press release would not be very helpful. Staff must have been aware that it would be seized upon by the tabloid media to cause all sorts of panic but simultaneously generate lots of publicity for the *BMJ*.

Most of my patients were easily reassured because it's obvious that a strong link with this popular drug would have become apparent years ago, and luckily the story fizzled out quite quickly.

I would like to have been a fly on the wall, however, when the story first broke in Crookes's head office and I propose a hypothesis of my own: there may be a link between stories like this and the chance of pharmaceutical company executives having a heart attack.

Northern Ireland NOTEBOOK

The curse of the doctor's receptionist

I am now officially a patient. I suffered what I thought was stomach cramps but the pain suggested something more and, having dismissed an ulcer, my GP sent me for a scan suspecting gallbladder problems. My scan was performed promptly and efficient and the hospital told me the GP would be in contact.

Four weeks later there was no news. Following a minor attack in February, I contacted the surgery and spoke to an abrupt receptionist called Anne. "The results have come back clear," I was informed. So I'm OK, I thought. I had a severe attack at the beginning of March and the next day made an appointment to see my GP. It took two weeks.

I said I couldn't understand how this pain was not to do with my gallbladder. "It is," he calmly informed me. The letter from the hospital said "multiple stones ...

I spoke to an abrupt receptionist called Anne

surgery required". I explained that Anne had told me otherwise; he was embarrassed. He would make an appointment and hopefully it would be dealt with within six months.

Two weeks later I had a severe attack and was off work for four days. I was to collect a prescription at reception but it was closed for lunch. I returned at 3.30pm but due to the queue it was 3.55 before I was asking for my prescription. "There's none here for you. Can you call back?" My request to see the GP was bluntly dismissed. "He's teaching and cannot be disturbed."

Now, for the first time in our interaction, she made eye contact; it was an icy glare.

Written by a practising community pharmacist in Northern Ireland

PAGB PERSPECTIVE

Self-care is all well and good, but support is vital too

Doctors and pharmacists need to help us to help ourselves, argues Sheila Kelly, director of the Proprietary Association of Great Britain

People are ready and willing to practice self-care – but need help and support from doctors and pharmacists. That's the message from the recent Mori poll conducted on behalf of the Department of Health. The survey looked at self-care in the wider sense, not just minor ailments, and it establishes a baseline for future work.

It wasn't news to see that nine out of 10 people often treat minor ailments themselves but 82 per cent of people with a long-term illness also actively take a role in caring for it. Even those who have been to hospital return to self-care afterwards, with 64 per cent saying they take an active role in monitoring the illness which caused the hospital referral.

Putting this study alongside the recent BMA report on over the counter medicines, there is a clear need for doctors to ask their patients about their OTC medicine taking and to take on the role of provider of information.

The BMA report acknowledged the need for doctors to be more involved but focused on electronic patient records as the means of collecting that information.

As usual, doctors came top of the list of sources of health information and people want them to provide more. Despite doctors complaining that too many of their patients are visiting them unnecessarily, the Mori survey showed that only around 28 per cent of people found that their doctor or practice nurse encouraged them to practise self-care all of the time or most of the time. The survey also showed that people know they visit a doctor sometimes when it is not necessary and they want to take care of their health but they need help to do so. Currently family and friends are the second highest source of information after doctors but people would like pharmacists to do more.

In this survey, as in many others, 13 per cent of people listed the pharmacist as a person who provides information, with 21 per cent of people saying that they would like pharmacists to provide more information in the future.

As the new pharmacy contract brings in requirements for pharmacists to provide health promotion information, perhaps this is the opportunity to get that percentage to increase.

Meanwhile, surveys continue to show that when people speak to a pharmacist they get good quality, helpful and trustworthy information but it seems that it doesn't happen as often as people would like it to.

This article can help in the following CPD competencies: **C1f, G1c, G1a, C1a.** A list is available at *www.uptodate.org.uk/home/PlanRecord.shtml*

New thoughts on stroke prevention

Dr Mike Mead outlines the latest NICE guidance on secondary prevention

Stopping smoking is one of the key factors to consider when trying to prevent stroke

The new National Institute for Health and Clinical Excellence guidance on the use of clopidogrel and modified-release dipyridamole in the prevention of occlusive vascular events has important implications for pharmacists.[1] Occlusive vascular events are transient ischaemic attack (TIA), ischaemic stroke, myocardial infarction and peripheral arterial disease.

Stroke is the biggest single cause of disability in the UK and is one of the most expensive conditions for the NHS (one fifth of acute hospital beds are occupied by stroke patients). Stroke consumes up to 5 per cent of a primary care trust's budget.

In England and Wales each year there are 110,000 new cases of stroke and 30,000 TIAs. Twenty three per cent of people die within 30 days of their stroke, while 25 to 30 per cent of stroke survivors remain permanently disabled. The annual cost of stroke in the UK has been estimated at £1.7 to 2.3 billion.

The prevention of stroke hinges on a range of factors including treating hypertension and hypercholesterolaemia, stopping smoking and using warfarin in patients with atrial fibrillation. This NICE guidance focuses on secondary prevention in patients who have already had an occlusive vascular event like a stroke or TIA. The new recommendations are listed in *table 1* (right)[1].

The evidence for the first recommendation comes from the European Stroke Prevention Study 2 (ESPS2) where the combination of modified release (MR) dipyridamole 200mg plus aspirin 25mg twice daily was compared with aspirin 50mg daily alone or placebo over two years in 6,602 patients who had experienced a TIA or ischaemic stroke within the past three months.[2] Aspirin was more effective than placebo in reducing the risk of having another stroke. But there was an even lower incidence of stroke with

Continued on page 18 ▶

Table 1: Summary of the NICE guidance on prevention of occlusive events

The combination of modified-release (MR) dipyridamole and aspirin is recommended for people who have had an ischaemic stroke or a TIA for a period of two years from the most recent event. Thereafter, or if MR dipyridamole is not tolerated, preventative therapy should revert to standard care (including long-term treatment with low-dose aspirin).

Clopidogrel alone (within its licensed indications) is recommended for people who are intolerant of aspirin and either have experienced an occlusive vascular event or who have symptomatic peripheral arterial disease. Aspirin intolerance is defined as either proven sensitivity to aspirin-containing medicines, or history of severe dyspepsia induced by low-dose aspirin.

aspirin/MR dipyridamole (9.5 per cent) compared with aspirin alone (12.5 per cent) (relative risk 0.76).

The findings were:

- Stroke or TIA: 18.1 per cent incidence with aspirin/MR dipyridamole, 22.6 per cent with aspirin alone (relative risk 0.8).
- Other vascular events: 1.3 per cent with aspirin/MR dipyridamole, 2.3 per cent with aspirin alone (relative risk 0.55).
- Fatal and non-fatal ischaemic events: 12.5 per cent with aspirin/MR dipyridamole, 16.1 per cent with aspirin alone (relative risk 0.77).

The frequency of bleeding complications was similar in the aspirin/dipyridamole and aspirin groups.

NICE considered the evidence for clopidogrel, mainly from the CAPRIE study, concluding it was at least as effective as aspirin for preventing occlusive vascular events.[3] However, in CAPRIE the significant effect in event reduction was for patients with peripheral arterial disease rather than stroke. While clopidogrel is licensed for the prevention of atherothrombotic events in people who have had an ischaemic stroke if given within six months but not before seven days after the event, the drug's current UK marketing authorisation does not cover TIA.

Regarding cost-effectiveness, the suggested strategy using two years of aspirin/dipyridamole followed by standard treatment with aspirin resulted in a cost per additional quality-adjusted life year (QALY) relative to aspirin of £5,500 and £2,241 for a stroke or TIA respectively. Treatment with clopidogrel in stroke resulted in high cost per QALY compared with aspirin/MR dipyridamole.

Assuming 6 per cent of the population are aspirin intolerant, the cost of treating all aspirin-tolerant stroke survivors and people with TIA with aspirin/MR dipyridamole would be £11.9 million for the first year in England and Wales (about £39,000 per PCO). In deciding whether patients are truly intolerant of aspirin, severe dyspepsia must be differentiated from mild dyspepsia – many patients intolerant of higher dose aspirin may tolerate low dose aspirin.

For pharmacists and prescribing advisers the key things to look out for are:

- Checking that patients with newly diagnosed stroke or TIA are prescribed twice daily the combination of modified release dipyridamole 200mg and aspirin 25mg (that is, the combination used in ESPS2 on which the NICE recommendation is based). This will particularly apply to patients discharged from hospital. For those stroke patients truly intolerant of aspirin, clopidogrel is the alternative within licensed indications.
- Educating those in primary care about the effective use of antiplatelet therapy post-stroke or post-TIA and adding the NICE recommendations to the PCO prescribing formulary.
- For prescribing advisers, taking into account the cost of the NICE recommendations when PCO prescribing budgets are allocated.
- Educating patients on the importance of continuing with their antiplatelet therapy post stroke/TIA. While this means a cost to the PCO, the key issue is the devastating effect stroke can have on a patient's life. The secondary prevention of stroke is one of the most important areas of therapeutic intervention.
- Recommending that stroke and prescribing of the combination of modified release dipyridamole 200mg and aspirin 25mg is included as one of the therapy areas for repeat dispensing services under the new pharmacy contract to aid compliance and prevent further strokes.

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Dr Mike Mead, a full-time GP in Leicester, is an adviser to many medical journals, author of medical books, and lecturer on medical matters in the UK and overseas.

He is on the healthcare advisory panel of the Blood Pressure Association.

Chaste tree

Chasteberry extracts may be useful in some women's ailments, says *Professor Edzard Ernst*

Chaste tree *(Vitex agnus castus)* is a deciduous shrub from the Mediterranean. In ancient times it was used for promoting chastity in women and celibacy in monks. Other traditional uses have a clear focus on women's health and include amenorrhoea, infertility, dysmenorrhoea, premenstrual and menopausal problems. Today, the latter two indications are the most important ones and the herbal remedy is widely used, particularly in Germany, for these conditions.

Pharmacology

The main constituents of the berry, the part used medicinally, include diterpenes, flavonoids, iridoids, linoleic acid and volatile oils. *In vitro* and *in vivo* studies have revealed hormonal (hypoprolactinaemic, oestrogenic and dopaminergic) effects as well as antimicrobial (antibacterial and antifungal) activity.

Does it work?

Two randomised controlled trials (RCTs) tested whether

chasteberry extracts were effective for corpus luteum deficiency.[1,2] In both cases the result was positive. Four trials for premenstrual syndrome are summarised in Table 2.[3,4,5,6] All these studies were of at least satisfactory methodological quality.

Collectively the evidence that chasteberry extracts are effective in this condition seems encouraging. In addition, three RCTs suggest that chasteberry extracts reduce the symptoms (pain) of cystic mastalgia.[7,8,9]

Table 2: RCTs of chasteberry for premenstrual syndrome and cyclic mastalgia

First author (year)	Study design	Sample size	Main outcome
Turner (1993)[3]	Double-blind, placebo-controlled, two parallel arms	600	No evidence for symptomatic improvement
Lauritzen (1997)[4]	Double-blind, equivalence study against vitamin B_6, two parallel arms	127	Encouraging evidence suggesting equivalence to vitamin B_6
Schellenberg (2001)[5]	Double-blind, placebo-controlled, two parallel arms	178	Strong evidence for symptomatic improvement
Atmaca (2003)[6]	Single-blind, equivalence study against fluoxetine, two parallel arms	42	Encouraging evidence for reduction of dysphoric symptoms

Is it safe?

In my view, because no positive safety data exists, chasteberry extracts should not be taken by pregnant or lactating women.

According to a large (n = 1,634) observational study, adverse effects occur in only 1 per cent of all patients.[10] They include problems like gastrointestinal symptoms, intra-menstrual bleeding, alopecia, fatigue, agitation, tachycardia, dry mouth, headache and nausea.[11]

Theoretically, extracts could interfere with hormonal treatments but there is little clinical evidence to suggest that this is the case.

Dose

The dose frequently used in clinical trials is 40mg of standardised extract per day in divided doses.

Conclusion

There is reasonably good evidence to show that chasteberry extracts are a symptomatic treatment option for premenstrual problems and cystic mastalgia. However, more evidence would be welcome.

The risks associated with this therapy are minor. Thus chasteberry extracts can be cautiously recommended, particularly for patients who prefer a herbal treatment.

Edzard Ernst, MD, PhD, FRCP, FRCPEd, is professor of complementary medicine, Peninsula Medical School, Universities of Exeter and Plymouth.

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Scriptlines

Parkinson's drug

Teva and Lundbeck have launched Azilect 1mg tablets, a new therapy for Parkinson's disease (PD).

Containing rasagiline, an irreversible monoamine oxidase-B inhibitor, Azilect is indicated for the treatment of idiopathic PD, either as monotherapy or as an adjunct to levodopa in patients with end of dose fluctuations. Recommended dosing is 1mg once daily, with no modification necessary for elderly patients or those with renal impairment.

The SPC states that the product is contraindicated in severe hepatic insufficiency, and recommends avoiding use in patients taking sympathomimetics, fluoxetine, fluvoxamine or dextromethorphan, and in those with moderate hepatic impairment. In addition, the drug should not be used in conjunction with pethidine or other MAOIs, and caution should be exercised when administering to patients on any antidepressant, the SPC says.

Research has demonstrated that rasagiline, when compared to placebo, significantly improves motor function, the main symptoms of PD and quality of life. Further studies have shown the drug's benefit when used with other therapies, including levodopa, dopamine agonists and entacapone, particularly in reducing the amount of 'off' time experienced by patients.

Price: 28 tablets £70.72
Pip code: 314-2858
Lundbeck Ltd, tel 01908 649966

Honey dressings on the NHS

Medlock Medical has launched Mesitran, a honey based range of wound products.

NHS-prescribable from August 1, the range comprises two ointments and three dressings. Mesitran Ointment contains 47 per cent medical grade honey, whereas Mesitran Ointment S contains 40 per cent and is suitable for sensitive wounds. The dressing range includes adhesive and non-adhesive dressings

containing 30 per cent and a mesh dressing containing 20 per cent honey.

The company says the products provide a bacterial barrier, maintain a moist wound healing environment, prevent maceration and absorb low to moderate levels of exudates. Medlock adds that the range can be used on pressure ulcers, first and second degree burns, diabetic ulcers, superficial wounds and donor sites.

Price and pip code: see *Price List*
Medlock Medical Ltd
Tel: 0161 621 2100

Some Cox-2s OK but class review needed, says EMEA

The benefits of some Cox-2 inhibitors outweigh the risks but research has highlighted the need to review the safety of NSAIDs, the European drug regulator has said.

Concluding its Cox-2 review, the European Medicines Evaluation Agency recommended the following contraindications and warnings for celecoxib, lumiracoxib, etoricoxib and parecoxib:

- Contraindicated in patients with established ischaemic heart disease, stroke or peripheral artery disease.
- Use with caution in patients with risk factors for heart disease, eg heart disease, hyperlipidaemia, diabetes and smoking.
- Use the lowest effective dose for the shortest treatment duration.
- Strengthen warnings that hypersensitivity and fatal skin reactions can occur, particularly in patients with a history of drug allergics.

In addition, the agency has recommended the suspension of Bextra (valdecoxib), an action that was taken voluntarily by the drug's manufacturer in April *(C&D, April 16, p30)*. EMEA said the product could be reintroduced within a year if Pfizer provides further data, particularly evidence of safety.

However, EMEA has said that its review has raised questions over the safety of NSAIDs as a class. Using studies that compare Cox-2s and conventional NSAIDs as a basis, the organisation said it would be undertaking a review of the whole drug class before making recommendations on their use.

For more information:

www.emea.eu.it

Arimidex approved for wider use

AstraZeneca has been granted a licence extension for Arimedex (anastrozole), allowing the drug to be used in all postmenopausal women with hormone receptive positive breast cancer.

The Medicines and Healthcare products Regulatory Agency has permitted wider use of the aromatase inhibitor following a trial that looked at the efficacy of tamoxifen and anastrozole, both singly and in combination. The findings showed that anastrozole reduced the risk of breast cancer recurrence by an additional 26 per cent over the 50 per cent reduction provided by tamoxifen.

In addition, recent analysis of the trial found that anastrozole significantly reduced the risk of recurrence during the first 18 to 24 months after surgery, when breast cancer is statistically more likely to return. Hence, the study authors recommended patients start the drug immediately after surgery to reap the most benefit.

Anastrozole has been found to reduce the risk of breast cancer recurrence more than tamoxifen

Early ropinirole helps PD in long term

Starting patients on ropinirole as soon as they are diagnosed with Parkinson's disease results in better long term outcomes, a small scale study has found.

Regardless of subsequent therapy, patients who were initially given ropinirole developed significantly fewer dyskinesias that those who began with levodopa (52.4 per cent versus 77.8 per cent). In addition, the ropinirole group experienced a greater number of years before the onset of dyskinesias without any negative impact on motor symptoms, the study found.

Presenting the paper at June's International Congress on Parkinson's Disease, lead author Oliver Rascol commented that the research was unusual because it followed up patients for 10 years. Dr Rascol concluded that the findings "support the early use of ropinirole as part of a long term treatment strategy for PD patients".

Scriptlines

Nurofen packs for dispensing

Crookes Healthcare has launched two Nurofen for Children (ibuprofen) dispensing packs, in 100ml and 150ml pack sizes.

Available from wholesalers at the beginning of August, the company says the packs will make dispensing easier for pharmacists, as the bottles do not have bungs or syringes and each box contains a double-ended medicine spoon.

Price: 100ml £1.89, 150ml £2.49

Pip code: 100ml 207-3708, 150ml 045-8844

Crookes Healthcare Ltd

Tel: 0115 953 9922

Wyeth stock shortages

Wyeth has said it is unlikely to resolve the supply issues it is experiencing within the next two months. The affected products are Ovranette and Premique Cycle tablets, Novantrone vials and Zoton 30mg sachets. The company says the shortages have arisen because of a need to update the marketing authorisation documentation for the products, and more products may be affected in the future.

A full list is available at *www.wyeth.co.uk* and will be updated weekly.

For more information:

Wyeth Pharmaceuticals

Tel: 0845 330 0509 (availability), 01628 685461 (medical information)

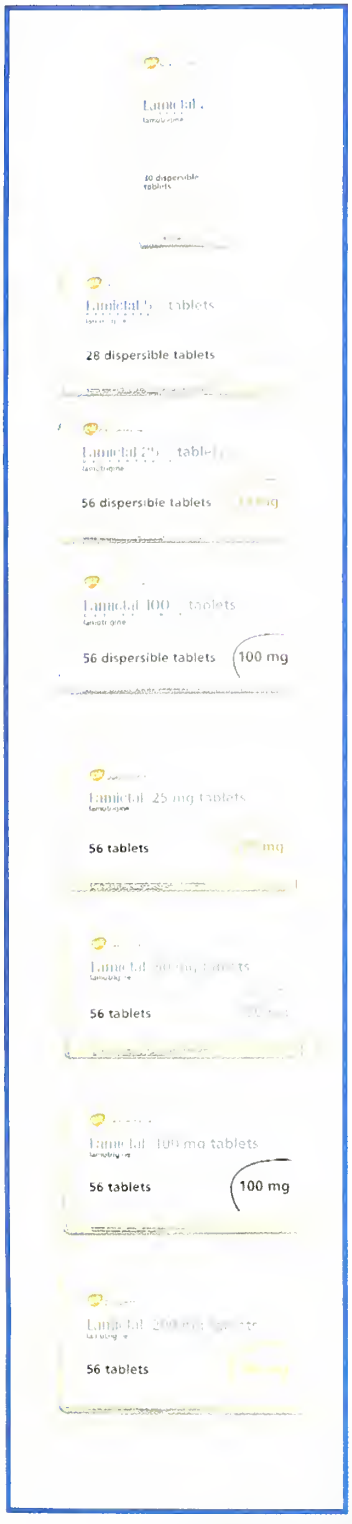
Zinnat sachets

Zinnat granules for suspension sachets 125mg 14s are being discontinued by GlaxoSmithKline. The manufacturer said stocks are likely to be exhausted by the end of this month and all other Zinnat products remain available.

For more information:

GlaxoSmithKline customer contact centre

Tel: 0800 221441



Lamictal™

lamotrigine

Do you want to provide a consistent supply of Lamictal, GlaxoSmithKline's anti-epileptic drug, for your established patients following the patent expiry on 29th May 2005?[1-7]

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0800 221 441

Freephone 0800 221441
Fax 020 8990 4328
customercontactuk@gsk.com

customer contact centre

GlaxoSmithKline

PLUS®

Fish oil is aimed at the children

BR Pharmaceuticals is introducing a value-for-money fish oil supplement.

Valupak Smart Omega 3 Fish Oil can be used by children from age three and contains a high level of docosahexanoic acid (DHA) as well as vitamins A, C, D and E.

Available in packs of 30 (£2.49) or 90 (£6.99) capsules, pharmacists can buy a unit of six packs of 30s for £8.52 or 90s for £23.93.

During July and August customers will get 108 capsules for the price of 90.

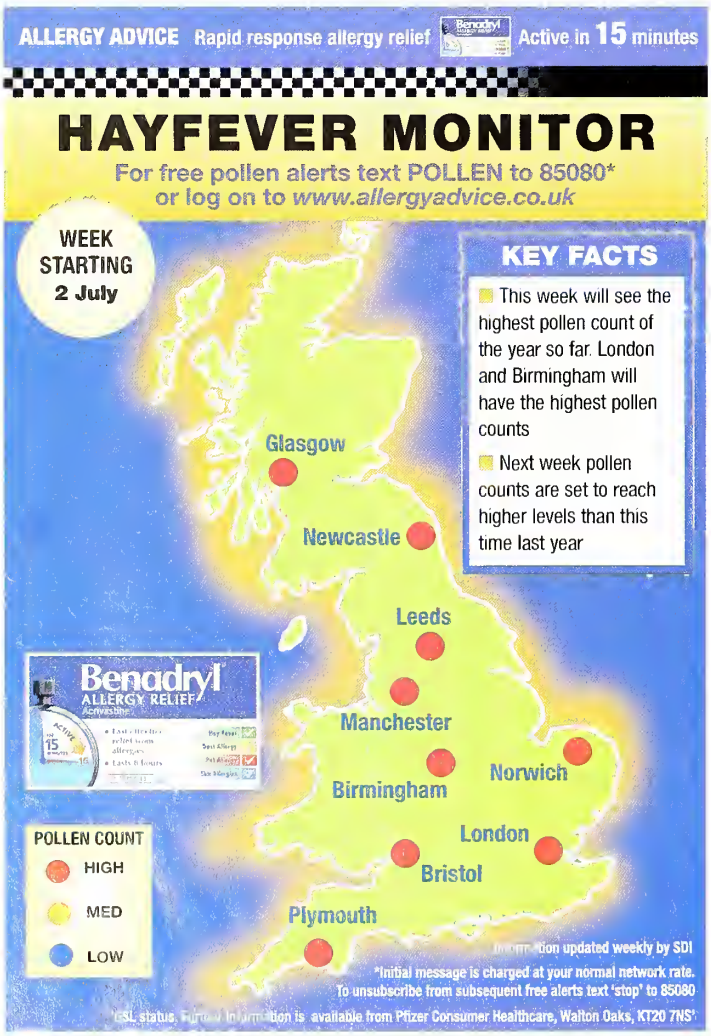
For more information:
BR Pharmaceuticals Ltd
Tel: 0845 230 1499

Potter's joins the sports club

Potter's is teaming up with sports retailer JJB to offer customers advice on herbal medicines.

JJB Fitness clubs in Wigan, Blackburn and Southport are stocking four complete ranges of Potter's herbal medicines: Tabritis, Femmeherb, Allerclear and Echinacea.

For more information:
Potter's Herbal Medicines
Tel: 01942 405103



Abbott makes a stand in-store

Abbott Diabetes Care is supporting the launch of its blood gluocose monitors Freestyle Mini and Optium Xceed with in-store display units.

The counter-top stands allow customers to operate the meters and include two perspex leaflet holders. The A4 backing board can be changed, allowing pharmacists to highlight price promotions or new activity.

The manufacturer claims that Freestyle Mini is the world's smallest meter, whereas the Optium Xceed is one of the easiest to operate: a recent trial found that 92 per cent of patients swapped their existing meter for the Xceed.

The launch of the meters is being backed by a £500,000 consumer campaign.

For more information:
Abbott Diabetes Care
Tel: 01235 838590

Deep Relief scoops second magazine award

Mentholatum's Deep Relief has been voted Best Health Product of the year by readers of *Health Plus* magazine for the second year running.

Available in 15g, 30g and 50g tubes (GSL) and a 100g tube (P), the gel is indicated for relief of rheumatic pain, muscular aches and pains and sports injuries.

For more information:
Pharma Consumer Care
Tel: 01202 314824
N Ireland Tel: 02890 814700

Seven Seas celebrates 70th birthday

Seven Seas is celebrating its 70th birthday by teaming up with *Saga* magazine to offer new subscribers a free pack of JointCare Projoint Formula.

As part of its birthday celebrations, the brand will also be sponsoring the Arthritis Research Campaign's Noddy appeal, which raises money for research into juvenile arthritis.

For more information:
Seven Seas Health Care Ltd
Tel: 01482 375234

One trusted maker, two trusted medicines

For children's pain and fever, healthcare professionals usually recommend paracetamol-based medicines such as Calpol first. In fact, Calpol is the number one recommendation for many.[1,2] Calpol is effective and can be used for babies from 2 months.

When recommending a second option, you know parents want a medicine they can trust.[3] Calprofen is an ibuprofen for children over 6 months. For parents it's a reassuring alternative because it's from the makers of Calpol, children's medicine specialist for 39 years.[3] Just like Calpol, Calprofen has a great strawberry taste to make dosing easier. Calpol and Calprofen – recommend with confidence.

Children's medicine specialist

Calpol Infant Suspensions Product Information: Presentation: Suspension containing 120mg Paracetamol per 5ml. **Uses:** Treatment of mild to moderate pain and as an antipyretic. **Dosage:** *Children 1 to under 6 years:* 5 – 10ml; Repeat dose every 4 hours if necessary, up to a max of 4 doses in 24 hours. *Children 3 months to under 1 year:* 2.5 – 5ml; Repeat dose every 4 hours if necessary, up to a max of 4 doses in 24 hours. *Infants 2-3 months:* Post - vaccination fever or 2 months: 2.5ml and a second dose, if necessary, after 4-6 hours.Treatment of mild to moderate pain and as an antipyretic (Infants over 4kg, not born before 37 weeks) 2.5ml and a second dose, if necessary, 4-6 hours later. **Contraindications:** Hypersensitivity to paracetamol. **Precautions:** Caution in severe hepatic or renal dysfunction. Interactions with Domperidone, metoclopramide, colestryomine, anticoagulants, barbiturates, tricyclic antidepressants, alcohol, anticanvulsants and oral steroid contraceptives. **Pregnancy and lactation:** Consult doctor before use. **Side effects:** Rarely skin rash, other allergic reactions and blood dyscrasias. Hepatic necrosis and papillary necrosis have been reported following prolonged use. **RRP (ex-VAT):** 70ml bottle £1.66, 140ml bottle £2.97 12 x 5ml sachets £2.34. **Legal category:** Bottle: P. Sachets: GSL **PL holder:** Pfizer Consumer Healthcare, Walton-on-the-Hill, KT20 7NS. **PL number:** Calpol Infant Suspension: 15513/0004 **Date of preparation:** November 2004.

Calprofen Product Information: Presentation: Suspension containing 100mg Ibuprofen per 5ml. **Uses:** Treatment of mild to moderate pain and as an antipyretic. **Dosage:** *Infants 6-12 months:* 2.5ml three times a day; *Children 1-2 years:* 2.5ml three to four times a day; *Children 3-7 years:* 5ml three to four times a day; *Children 8-12 years:* 10ml three to four times a day. Not recommended for children weighing less than 7kg. **Contraindications:** Hypersensitivity. History of peptic ulceration. Individuals in whom Ibuprofen, aspirin or other non-steroidal anti-inflammatory drugs induce asthma, rhinitis or urticaria. **Precautions:** Hepatic or renal dysfunction, heart failure. Individuals with coagulation defects or receiving anticoagulant therapy. Caution in bronchial asthma or allergic disease. Care should be taken with antihypertensives including diuretics, cardiac glycosides, lithium, methotrexate, cyclosporine, mifepristone, other analgesics, corticosteroids, anticoagulants, quinolone antibiotics **Pregnancy and lactation:** Not recommended **Side effects:** GI disturbances, occasionally gastric ulceration and bleeding, hypersensitivity reactions and oedema. Other reactions that haven't necessarily been related to ibuprofen include renal and liver problems, neurological and sensory disturbance, haematological disorders and photosensitivity **RRP (ex-VAT):** £2.97 **Legal category:** P. **PL holder:** Pinewood Laboratories Limited, Ballymacarby, Clonmel, Co Tipperary, Ireland **PL number:** 04917/0044 **Date of revision:** April 2005.

References: 1. Counterpoint. Analgesics – Child 03 2004 TNS 2. Bayer. Healthcare Network. DFU Feedback 2005 3. Calprofen Qualitative Advertising Research, December 2003. Felicity Randolf and Associates

Pfizer Consumer Healthcare
www.calpol.co.uk

Calcium comes in chewable form

Viatris claims its newly launched product Osteo-life is the first chewable one-a-day calcium supplement.

The blackcurrant-flavoured tablets contain calcium and 200IU of vitamin D3 to improve absorption of calcium. Osteo-life is free from sugar, lactose, gluten and yeast and is suitable for vegetarians and vegans.

A survey commissioned by the manufacturer found that many people fail to take their calcium supplements because they find the taste unpleasant, the tablets too large to swallow, or multiple dosing regimens inconvenient. Viatris believes the new one-a-day supplement will address these issues.

Price: £4.99 for 28 day pack

Viatris Pharmaceuticals Ltd
Tel: 01223 205999

Eurax moves onto radio

Eurax is being supported with a radio campaign which runs throughout the summer from this week until the end of August.

The 30-second adverts will focus on the brand's ability to treat sunburn, insect bites, stings and rashes. Available as cream and lotion, it's suitable for adults and children, but under threes need a doctor's recommendation.

For more information:

Novartis Consumer Health
Tel: 01403 210211

Summer additions for Carnation

Carnation Footcare is expanding its range with the launch of three foot sprays to keep feet cool, dry and sweet smelling as the temperature rises.

Fresh Foot, Cool Foot and Fresh Shoe sprays are designed to tackle the summer problems of hot, sweaty feet and foot odour. All products are triclosan-free.

The launch is being supported with a PR campaign which will target women's and lifestyle press.

Price: 150ml £2.99

Activa, tel: 08450 606707

Sula's tooth-friendly mints

The Sula range of sugar-free sweets has been extended with two new variants.

Lemon Mint pastilles with vitamin C and breath-freshening Menthol Mint pastilles join the existing range of five products. The sweets come in convenient flip-top packs and are sweetened with natural sweetener Isomalt (derived from sugar beet).

Price: 50g pack £0.75

Petty Wood & Co
Tel: 01264 345500

Kids have fun with Johnson's

Johnson's Junior is a range of toiletries for two to five year olds, using the No More Tears formula.

The range includes Junior 2 in 1 Easy-Cleaning Bath & Shower, which foams instantly; Easy Foaming Hand & Face Wash, which foams and rinses quickly; Easy-Combing Spray for easier combing; Easy Rinsing Foam shampoo; and Easy-Combing shampoo.

Packs are vibrant and spill-proof.

Prices: all 250ml £1.99 except Easy-Combing spray, 150ml £1.99.

Johnson & Johnson Ltd
Tel: 01628 822222

Melt away unwanted hair

Skin Doctors Cosmeceuticals has moved into the hair removal market with the launch of two products.

Mousse Magic Hair Removal combines potassium thioglycolate with a blend of moisturisers to melt away hair and leave skin smooth without irritation.

SlowGrow Hair Minimising Moisturiser keeps skin silky soft while a complex of urea, soy peptides, witch hazel, arnica and salicylic acid will ensure hair grows back finer, sparser and less obvious with regular use.

Price: Mousse Magic (200ml) and SlowGrow (150ml) pack £16.99; SlowGrow individual pack, £10.95

CAT Industries
Tel: 0800 298 7200

Avent mother and baby gift sets

Avent has revamped its gift sets for babies and mothers-to-be.

The Future Mother Must-Haves set contains Moisturising Light Oil, Relaxing Bath & Shower Essence, Indulgent Body Cream and Leg & Foot Reviver. The Baby Must-Haves gift set includes Silky Liquid Talc, Soothing Magic Cream, No Tears Body & Hair Wash and Gentle Cleanser. Both are presented in reusable white mesh cosmetic bags with zip fastenings.

Price: £11.99 each

Cannon Rubber
Tel: 01787 267000

TV

Anadin Extra: All areas

Canesten AF: C

Freestyle Mini: GMTV

Germoloids: C4, five, GMTV, Sat

Imodium: All areas

Lanacane: All areas

Radox Shower: STV, C,A,HTV,M,LWT, CAR, C4, five, GMTV, Sat

Rennie: All areas except CTV, CAR

TENA Lady: All areas except U, CTV, LWT, GMTV

TENA Pants Discreet: All areas except U, CTV, LWT, GMTV

Traveleeze: GMTV

Zovirax Cold Sore Cream: C4, five, Sat

PharmaSite for next week: Bazuka – Window, **Hayfever Care Range** – in-store, **Pepto-Bismol** – Dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

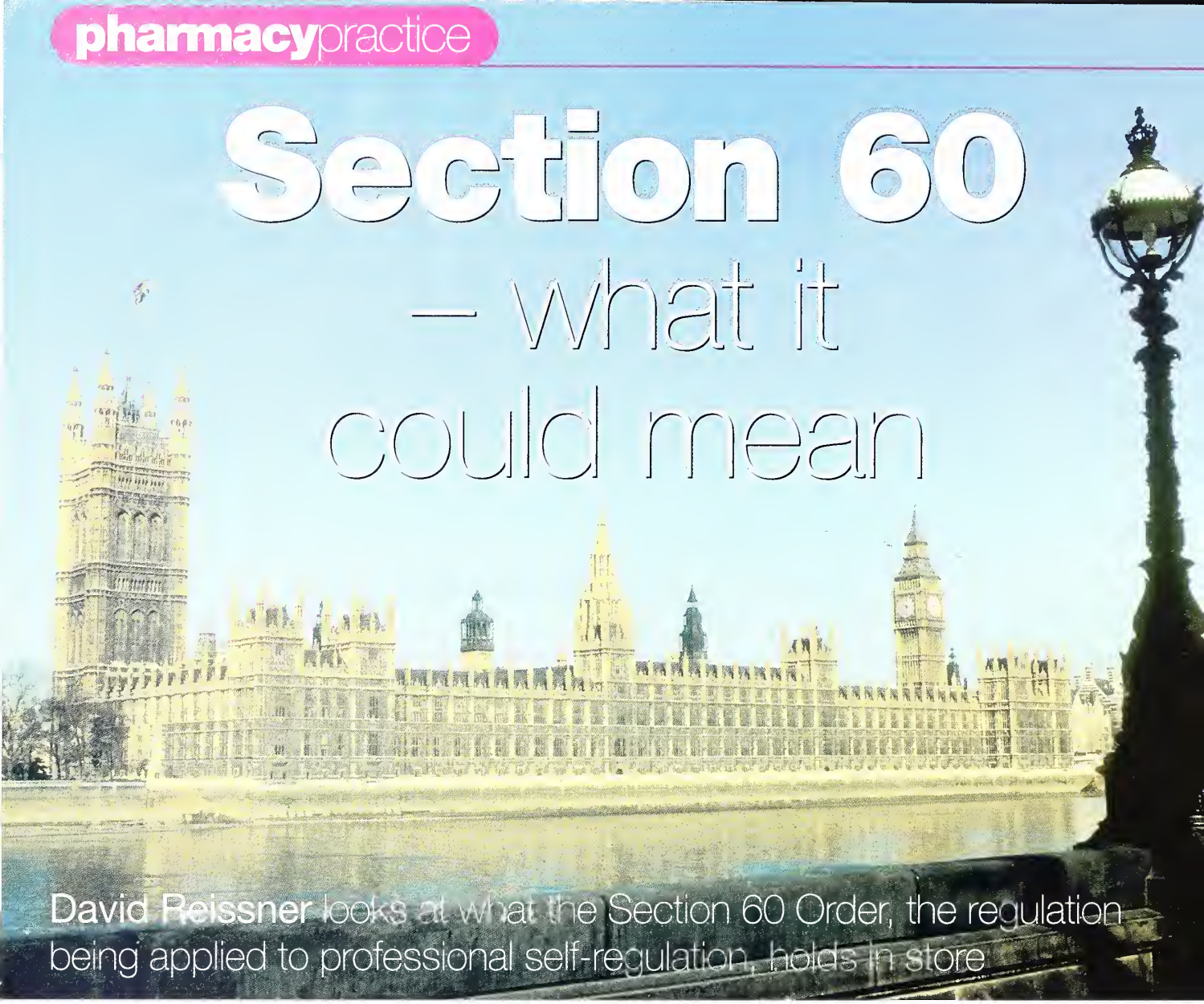
Sexual health training

Next week's issue of *C&D* will contain the latest Dendron training guide for pharmacy assistants, this time dealing with sexual health.

A quarter of women have orgasmic difficulties, with 40 per cent admitting to a current sexual problem, says Dendron. The *Vielle Sexual Health Training Manual* will explain the issues, medical conditions and possible treatments offered by Vielle.

For more information, www.vielle.com

Section 60 – what it could mean



David Reissner looks at what the Section 60 Order, the regulation being applied to professional self-regulation, holds in store

The Government has announced that its proposed consultation on new disciplinary procedures for the pharmacy profession has yet again been delayed. It is no secret that the profession's disciplinary procedures are out of date. The Government has had powers to do something about it since Section 60 of the *Health Act 1999* came into force.

However, although a promised consultation has been delayed, it seems some decisions over the future of pharmacy have already been made. Documents obtained under the *Freedom of Information Act* show that discussions over the contents of a Section 60 Order between the Department of Health and the RPSGB are well advanced, and a draft Section 60 Order has already been prepared. While a formal consultation may provide an opportunity to persuade the Government to make changes, it is possible to predict what is in store when a Section 60 Order finally comes into force.

The new rules will extend to registered technicians as well as pharmacists. General provisions which the Society would like to see covered in a Section 60 Order include:

- Power to set its own fees.
- Imposing a duty on the pharmacy owner, corporate owner or pharmacist in charge to notify the Society if any of them cannot control how the business operates, for example by absence abroad for more than 28 days, retirement or serious illness. The imposition of such a duty on pharmacists in charge may be unworkable, since the pharmacist in charge may be a temporary locum, so the Society will probably have to give further thought to this.
- In future, superintendent pharmacists will have to notify the Society if they resign, and companies will have 28 days in which to notify the Society of the appointment of a new superintendent.
- The Society will be able to impose fines if a pharmacy owner fails to comply with an inspector's requirement to make premises improvements, for example supplying hot water to a sink.

Despite official delays on a consultation on disciplinary procedures for pharmacy, the Government has been in talks with the RPSGB for some time

Currently, pharmacy has no means of dealing with pharmacists who are unfit to practise as a result of health problems. Such cases are often treated as misconduct and referred to the Society's Statutory Committee where pharmacists suffering from alcohol or drug dependency may be struck off, even if they are in recovery. Under the proposed Section 60 Order, the Society will have a Health Committee. Cases involving an allegation of misconduct or a conviction for a criminal offence will be referred to a Disciplinary Committee.

Both committees will be able to make an order before a final hearing, suspending a pharmacist or pharmacy technician, or making their continued registration subject to conditions, where this is considered necessary to protect members of the public or is otherwise in the public interest. These powers cannot be exercised unless the pharmacist or technician has been given an opportunity to be heard by the committee.

Currently, the Statutory Committee cannot direct the removal of a pharmacist's name from the Register or even administer a reprimand unless a finding has been made that the pharmacist is found to be unfit to be on the Register. Under the proposed new rules, the Health Committee or the Disciplinary Committee will instead have to consider whether, as a result of the allegation being made, the pharmacist or technician's fitness to practise is impaired. There seems to be a subtle but important difference between a pharmacist whose misconduct or conviction renders him unfit to be on the Register and a person whose fitness to practise is impaired. Impairment

suggests a reduction in ability to perform functions – something less than a perfect state of affairs – whereas being unfit implies a higher standard than impairment.

If the lower standard of impairment is met, the Health Committee or the Disciplinary Committee could suspend registration or make a person's registration conditional upon compliance with specified conditions. In misconduct cases or conviction cases the Disciplinary Committee could additionally direct removal from the Register or that a pharmacist or technician be reprimanded.

Pharmacists who have been struck off for misconduct would be prohibited from any involvement in a pharmacy business. It is not unusual for pharmacists who are struck off to transfer their businesses to a company, and appoint a superintendent pharmacist, while continuing to deal with administration or assisting the pharmacist in charge in dispensing. This has not caused any significant difficulty in the past. The superintendent pharmacist would have to exercise his or her duties in accordance with the Society's standards. When a suitable period of time has gone by, the Statutory Committee has often concluded that it was appropriate to restore the pharmacist in question to the Register. The proposal to prevent a struck off pharmacist from working in a pharmacy owned by a company suggests that the Society either does not trust superintendent pharmacists or the Statutory Committee – or both.

In a case where a pharmacist or technician's name has been removed from the Register as a result of misconduct or a conviction, it is proposed that an application for restoration could not be made until five years has expired since the date of removal. This is more draconian than the current arrangements where there is no time restriction. Currently, the Statutory Committee will not usually consider that an application for restoration is premature if it is made once three years have expired. Imposing a statutory time limit would take away the discretion to reinstate someone who has been rehabilitated. In exceptional cases in the past, the Statutory Committee has occasionally seen fit to restore former pharmacists to the Register after six months. The removal of discretion to restore a pharmacist to the Register within five years seems a retrograde and unnecessary step. Even if the Statutory Committee is not trusted to make suitable decisions about restoration, its decisions will always be subject to review by the Council for Healthcare and Regulatory Excellence, which has statutory powers to challenge decisions that are considered unduly lenient.

The removal of discretion to restore a pharmacist to the Register within five years seems a retrograde and unnecessary step

The RPSGB is seeking enhanced powers including setting its own fees and imposing fines for a variety of unmet criteria

The power to restore former pharmacists to the Register may be circumscribed even further by proposals that if a restoration application is unsuccessful, no further application can be made within the following 12 months, and if a second application for restoration is unsuccessful, the Disciplinary Committee can suspend indefinitely the right to make any further application. If restoration is granted, the Society has been trying to persuade the DoH to allow conditions to be attached (eg supervised practice) in appropriate cases. This seems eminently sensible, but the Department has so far been resisting the suggestion.

Currently, the Government is proposing that there should be a right of appeal against decisions of the Health Committee and Disciplinary Committee to a new body, the Registration Appeals Committee. Details of this are as yet unclear, but it appears that this would replace the current right of appeal to the High Court against a striking off decision (there is no right of appeal against a reprimand under the present regulations). It appears that the current role of the anonymous Privy Council, which has to approve certain restorations, acting behind closed doors, will be abolished.

Modernising and tightening up disciplinary procedures as well as making provision for dealing with pharmacists unfit to practice through ill health are much needed, but rehabilitation is definitely out of fashion.

David Reissner is a partner with law firm Charles Russell LLP.

The changing landscape

Coleraine, Northern Ireland was the setting for June's 31st UKMi Medicines Information conference last month. Hot topics included marketing, pre-registration training and complementary medicines reports **Asha Fowells**

Medicines information (MI) services need to be more effectively marketed if they are to appeal to community pharmacists, Terry Maguire told delegates at the UKMi conference.

Dr Maguire, a community pharmacist, said he rarely used NHS MI services, preferring resources such as the *British National Formulary*, manufacturers' product information, *Martindale*, pharmacy journals and websites. He argued that many of his community pharmacy colleagues felt the same way, often thinking that their queries were "not important enough".

But the growing clinical role of community pharmacists – fuelled by government health policy and the introduction of new pharmacy contracts – meant many need to improve their clinical knowledge, and MI services have a role to play in this. Dr Maguire called for MI service providers to look at why they were under-utilised by their primary care colleagues, and modify their services in light of the changing healthcare system.

MI providers need to develop a robust strategy based on sound business planning that clarifies the service's mission, said Dr Maguire. This needed to identify MI's core business, its unique selling point and whether it delivered what its customers wanted. Failure to do so would result in MI failing to compete in an increasingly competitive marketplace.

In addition, he recommended developing a marketing plan. People only buy or use things they want or need, warned Dr Maguire, saying that MI pharmacists needed to be aware that the service they provided was a product. He concluded: "Marketing is one of the most important issues. Pharmacy is changing, so you need to look at how you can address its changing needs."

> "Pharmacy is changing so you need to look at how you can address its changing needs"
>
> Terry Maguire

Review MI services, says chief pharmacist

Medicines information services must be reviewed to meet the needs of a changing healthcare system, said Northern Ireland's chief pharmaceutical officer.

Such services must increase their contact with community pharmacists because "that's where most of the patients are", said Dr Norman Morrow. To integrate fully, it was important that MI pharmacists considered how their work impacted on both patient health and healthcare policy by using figures that proved hospital stays and readmissions dropped when effective MI services were in place.

Effective use of technology is another key area for these services, which must be up to date with innovations such as biotechnology and new imaging techniques, continued Dr Morrow. However, he warned of the danger of using IT to such an extent that pharmacists lost their cognitive skills.

In addition, there is a need for specialist MI services to be expanded, said Dr Morrow. "There must be a greater emphasis on practice and skill mix, and you need reporting for information to counter inappropriate practice," he said, adding that MI also had a role to play in providing advice on new products where the evidence for their use was "not compelling".

Care needed with third party queries

Pharmacists must be careful when they deal with third party enquiries, warned a medical law expert.

Barrister Tony McGleenan (right) said pharmacists "should not answer third party enquiries unless there is a compelling reason to do so". Furthermore, reasons for responding to – or refusing to answer – such a query should be carefully recorded so there is evidence in case of any future comeback, he recommended.

Although health professionals often worry about breaching patient confidentiality, Professor McGleenan said privacy was a more pertinent issue. Article 8 of the *Human Rights Act* states that "everyone has the right to respect for their private and family life" and this should only be breached if it is necessary for the protection of health, he explained.

In addition, Professor McGleenan gave advice for pharmacists who were asked to act as expert witnesses in court cases:

- Remember that the role of an expert witness is to assist the court by providing independent, objective evidence on matters of specialised knowledge.
- Do not bias your evidence towards one side of the case – you do not have to show loyalty to the party paying your bill.
- Don't offer an opinion on anything that is outside your area of expertise, or try to judge the case's "ultimate issue".
- Prepare your report before the hearing and expect to be asked to support its findings.
- Know that you can talk to "the other side" before the hearing, and failing to comply with such a request can make you look like "a hired gun".
- Understand the courtroom dynamic that dictates questions will be asked by lawyers, but must be answered to the judge.

MI prescribing role

The demand for medicines information services will increase if independent prescribing is approved, delegates were told.

Such services would be more useful to community pharmacy if they could provide evaluated trial appraisals and therapeutic class overviews, said supplementary prescriber pharmacist Fiona Reid, (pictured left). She also suggested that MI could have a role in facilitating local networking to reduce the isolation felt by many supplementary prescribers and to spread best practice.

Heralding supplementary prescribing as a positive step, Ms Reid said she had met little resistance from the GPs or the 200 patients she had dealt with. However, issues she had identified included handwriting prescriptions, the inability to address concurrent co-morbidity, time pressures and a lack of information from the RPSGB on what to do at a patient's annual review.

EC law to improve **herbal safety**

European legislation to be introduced in October will simplify the registration procedure for herbal medicines in the UK, said a Medicines and Healthcare products Regulatory Agency spokeswoman.

The EC directive on Traditional Herbal Medicinal Products will enable the UK drug regulator to know which products are available, their contents, and how they are manufactured and distributed, said MHRA pharmaceutical assessor Linda Anderson. The law will also ensure the public has access to safe, high quality herbal remedies and information on how to use them, she added.

Currently, the majority of herbal products available in the UK are unlicensed. However, although goods that do not have product licences cannot make therapeutic claims, many claim to offer "health benefits", resulting in confusion about how they can be safely used, or in which patient groups, Dr Anderson explained.

However, under the directive, products would not necessarily have had to undergo rigorous clinical tests. Although companies would need to submit expert safety reviews as part of product licensing applications, Dr Anderson warned: "No evidence of risk is not the same as evidence of no risk, and traditional or longstanding use is no guarantee of safety."

The MHRA would rely on pharmacovigilance to highlight any safety issues, said Dr Anderson, urging pharmacists to report all adverse drug reactions via the Yellow Card scheme. Only then could the regulator identify problems and request further safety data from manufacturers, she pointed out.

Spotlight on recruitment

Alliance Pharmacy offers careers that are varied and provide scope for personal development, David Cooper, senior manager, reward and resourcing, tells *C&D*

Q: How many pharmacists do you employ?

Alliance Pharmacy has more than 8,000 employees across 878 stores, of which about 1,000 are pharmacists.

Q: When was the company set up?

Alliance Pharmacy, formerly known as Moss Pharmacy, was founded in 1915 by Edgar Moss, with its first branch in Feltham.

Q: Why the name change?

The rapid growth of the company resulted in the business trading under a number of different names, shop fronts and imagery, which meant we had no consistent way to communicate with consumers, PCTs, doctors' surgeries, hospitals and local/regional government bodies. By introducing the single Alliance Pharmacy brand we will be able to communicate a clear and consistent message to our customers. Trading under a single name will also strengthen our position within the Alliance UniChem Group, as we will be seen as part of a pan-European company that has produced record financial results over the years.

Q: What career prospects would you offer a pharmacist?

Careers that progress through professional or clinical roles as well as management roles (district, area and regional). We also offer alternative areas such as training, marketing and human resources.

Q: Would there be scope for a pharmacist to stay dispensing, or does the role also involve managing staff and budgets?

There are many locations where the pharmacist can concentrate on the clinical and technical aspects of their profession. Many, however, enjoy managing a small business.

Q: What training do you offer?

We encourage and support pharmacists with CPD and most recently for medicines use review accreditation. Again, similar to most multiples, we provide pre-registration training for pharmacist graduates. There is also a management development programme for those who aspire to a career in line management. All these involve spending time away from the branch, meeting other colleagues and enabling everyone to build internal networks and working relationships.

Q: Are your pharmacists encouraged to bring in new business?

The new NHS contract presents an exciting opportunity for pharmacists to really contribute through their specialist knowledge and skills. Building relationships with other healthcare professionals, particularly in local GP surgeries or through PCTs has started to enable successful delivery of new services such as cardiac risk assessment, smoking cessation and diabetes testing - all tailored to local needs.

Q: What financial incentives do you offer someone considering a career with you?

We offer competitive salaries and bonuses, along with a range of benefits that individuals may choose. We aim to provide the greatest flexibility for their personal circumstances.

Q: How are you responding to changing attitudes to work?

We offer a variety of work opportunities – part-time, job shares, etc – where people are able to get involved in other activities. This may include working in a GP's surgery, facilitating training events or undertaking part-time study.

Q: Why should a pharmacist choose to work for you?

We have a long history of professionalism and believe everyone should be given the opportunity to contribute in helping us deliver the best service to our customers and patients. Having evolved from a supportive family organisation, we believe the ingredients that contributed to that success still contribute towards making Alliance Pharmacy what it is today.

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On yer **bike!**

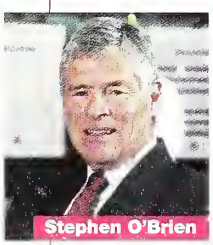
David Jeyes of Jeyes Chemist in Northampton will be setting off for John O' Groats next Sunday to start his charity 'Birthday Bicycle for Two'.

Mr Jeyes, who celebrates his 60th birthday, and his daughter Anna, who was 21 in March, are cycling 1,000 miles in a 23-day 'End to End' bike ride that will finish in Land's End.

The pair are cycling for the Northampton Soup Kitchen, which provides the area's homeless and disadvantaged with food, clothing, shower and laundry facilities, as well as education and development opportunities. Donations, payable to the Northampton Soup Kitchen, or raffle prizes can be sent to Mr Jeyes at Jeyes Chemist, 26-28 The Square, Earls Barton, Northampton NN6 0NA.

Ap o n m nt


Tanya Martin


Stephen O'Brien

Teva UK has increased its presence in Northern Ireland with the appointment of **Tanya Martin** as sales territory manager in the province. Ms Martin has worked in the pharmaceutical industry for seven years and joins Teva from Sandoz.

International Health Partners UK, the charity that handles donations of medical supplies to the developing world, has appointed **Stephen O'Brien** as its chairman. Mr O'Brien has spent his career in the financial sector, and his current positions include chair of governors of the University of East London.

Bernard Crump has been named chief executive of the NHS Institute for Innovation and Improvement, a new organisation set up to develop best practice, ideas and technologies for patients. A visiting professor at Leicester University's epidemiology and public health department, Professor Crump is a public health doctor whose most recent position was chief executive of Shropshire and Staffordshire health authority.

Ali Raza has joined emerging pharmaceutical company NicOx as head of research and development. Dr Raza's most recent post was head of clinical development and regulatory affairs at Renovo, before which he spent 14 years in a number of positions at AstraZeneca.

Carol Ferguson has been appointed a non-executive director of emerging pharmaceutical company Ardana. Mrs Ferguson has had a varied career in finance, including a period as a financial journalist and columnist for *The Times* newspaper and finance director of a textile design company.

If Ashwin Tanna were **Chancellor**..

... he would change the UK stamp duty system into one where the tax increases progressively according to the value of the property.

This is the idea that has won pharmacist Ashwin Tanna the Chartered Institute of Taxation's (CIOT) 'If I were Chancellor' competition. His prize included two tickets to see *Pericles* at Shakespeare's Globe and two magnums of Champagne.

The competition, which was run as part of CIOT's 75th anniversary, asked entrants: what single change to the UK tax system would you make, and why?

Under Mr Tanna's system, stamp duty would be payable in three bands: 0 per cent for the first £120,000, 1 per cent for the next £130,000 and 3 per cent for properties priced over £250,000. This would bring the duty payable on a £255,000 property down from the current £7,650 to £1,450. Mr Tanna argued that this would encourage first-time buyers to take the plunge.

Ashwin Tanna is seen here (left) receiving his prize outside The Globe theatre from CIOT deputy president John Cullinane.

New **senior business reporter** for *C&D*

C&D has a new addition to the team, Max Gosney. Max, who has a degree in biochemistry from Cardiff University, joins the magazine as senior business reporter. His CV includes two years at B2B publisher William Reed. Max is a keen sportsman and enjoys football, running and swimming. If you have any business news or information then call Max on 01732 377 315 or e-mail *mgosney@cmpinformation.com*

The curious case of the **2CV** and the **cow**

Bradford locum pharmacist Neil Harris and his partner Jan Williams will be driving a 20-year-old Citroen 2CV from London to Ulan Bator in an effort to raise funds for Africa and Mongolian children.

The three-week Mongol rally event, which starts on July 30, involves travelling 8,000 miles through two deserts and five mountain ranges on roads ranging from bad to non-existent – with no support crew and all in what the event organisers describe as a "crap car that you swapped for a bag of crisps".

Mr Harris bought his car on eBay for £379 (the previous £20 car proving too far gone to repair). To support his efforts to raise money for Send a Cow (to Africa) and Save the Children's fund (Mongolia), Mr Harris is inviting donations to: *www.justgiving.com/marvindoesmongolia*

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